

MEMO SERIES 2002-02
**THE INFEASIBILITY OF HOME CARE, QUALITY OF THE FACILITY AND ITS
SERVICES, CLIENT PREFERENCE, COST-EFFECTIVENESS, THE PRE-ADMISSION
ASSESSMENT & CBRF SIZE**

QUESTION AND ANSWERS

Determination that Home-care is Infeasible:

1. **Q:** What are the state's expectations in a situation where the applicant moves to a CBRF, exhausts their assets, and then seeks state long-term support funding, is it to be denied and this person forced to relocate if it is determined that home-care is feasible?

 A: If home-care is determined to be feasible for an applicant that has been residing in a CBRF or other substitute care setting, COP & Waiver funding is not allowed to be used to support that person in a CBRF. If the person chooses to reside in a home-care setting, or an Adult Family Home, or Residential Care Apartment Complex, etc., funding can be used.

2. **Q:** What if home-care is feasible, but the participant (or the participant's family) does not want to remain in their home?

 A: If home-care is feasible and a safe care plan can be put in place, in order to use this funding, they cannot be served in a CBRF. The statutes say that all of the conditions must be met, so that, even though the person prefers to live in a substitute care setting, home-care is feasible so funding cannot be used in a CBRF. Remember that these are conditions on the use of funding in CBRFs....not apartments or Adult Family Homes or Residential Care Apartment Complexes. If the person is adamant about not living at home, using this funding in other settings besides CBRFs can be explored.

Determination of Quality Environment and Services:

1. **Q:** Doesn't a state license attest to the quality care and environment of a facility?

 A: As stated in the memo, when purchasing services for an individual using public funding, it is a county's obligation to arrange and purchase quality services in a quality environment for consumers. People who are elderly, have a form of irreversible dementia, or have a disability have individualized needs that are not always addressed specifically for these populations in the licensing standards. There is a need, therefore, for individualized expectations of quality beyond

licensing standards that address the specific needs of these individuals when using the funds that support them.

2. **Q:** Are there any examples of quality criteria that counties have already created and incorporated into their contract that other counties can use as examples?

A: Yes. There are several counties that have incorporated quality standards into their contracts. BALTCR is in the process of obtaining examples for dissemination upon request.
3. **Q:** I don't want to be in a position of regulating facilities, isn't that what this really is?

A: It is not our expectation that you be in a position of regulating facilities, that is the State's job through the Bureau of Quality Assurance. However, our expectation is that counties are purchasing services that meet county expectations and ensuring that participants are receiving quality services. Building quality standards into your contracts establishes an agreement between parties, outlines your expectations, and provides a basis for nullifying a contract that is not meeting a county or consumer standard.
4. **Q:** What if a CBRF does not comply with the quality standards I incorporate into the contracts?

A: It will be important to build language related to non-compliance and monitoring into the contracts. Examples of this includes: terminating/suspending contract due to deficiencies, or withholding payments. You may want to say that the facility shall be monitored using the quality indicators you create, in that, you will be using these standards to evaluate the services the facility is providing to participants.

Determination of Client Preference:

1. **Q:** What happens if the individual and their family do not want to look at other alternatives?

A: The policy states that an individual shall have the opportunity to visit one or more CBRFs, and, when desired, other residential settings. If they choose not to visit other facilities, so long as they have had the opportunity to do so, this requirement is met.
2. **Q:** What if there are no private room options in our county?

A: If there are no private room options in your county, offer this option in another county. In addition, you may want to develop Adult Family Home options in your county where the individual can be offered a private room. The CBRF

industry, as it continues to develop, is moving toward private room facilities. When it's practical, work with developers in your area to expand this as a resource in your county.

3. **Q:** What if an individual prefers a private room, but the cost is too great?

A: Preference is only one criteria that must be met, cost-effectiveness is another. If a facility is not cost-effective, even though it is the person's preference, funding cannot be used in that CBRF. However, private rooms will simply cost more than shared rooms. Remember that cost-effectiveness should be determined in terms of comparable options that meet the "outcomes" of the person. For some, a private room in a CBRF is not comparable to a shared room or their personal goals and preferences cannot be met in a shared room environment. It is expected that this be considered when determining cost effectiveness.
4. **Q:** What if our county has a policy that says that they will not fund private rooms?

A: A county that currently has a policy that they will not fund private rooms, will need to change their policy to comply with this new requirement. A county is not required to fund private rooms in order for participants to reside in CBRFs using this funding, however, they are required to offer the option.

Determination of Cost-Effectiveness:

1. **Q:** Does this mean that COP/COP-W/CIP-II funding can only be used in the cheapest residence?

A: No. Cost-effective does not mean the cheapest or least expensive. It does mean that all of the consumers needs can be met at a cost that is reasonable in comparison with other community and nursing home alternatives. So that, if a person's outcomes can be met equally by the CBRF and home-care arrangements and the CBRF costs more, then the CBRF does not meet the cost-effectiveness test. Furthermore, if the CBRF can better meet the persons individualized needs at a higher cost than home care arrangements, then funding is allowable in the CBRF.
2. **Q:** What if home-care is less expensive, but the person prefers to reside in the CBRF?

A: You will need to do a cost comparison between the cost of in-home care and care in a CBRF when the person prefers it. Again, cost-effective does not mean least expensive. As stated above, if the CBRF can better meet the persons individualized needs at a higher cost than home-care, then funding is allowable.
3. **Q:** What if a CBRF is less expensive than home-care, but home-care has been determined to be feasible and the person prefers to live at home?

A: It is important to remember that these criteria must be met before funding can be used in a CBRF. If other community or home-care settings are preferred, these conditions do not need to be met. In other words, if home-care is preferred and feasible, even though the CBRF costs less, the individual should be supported in their home.

4. **Q:** What if the CBRF is NOT cost-effective, but is preferred by the resident/guardian?

A: As in several other variations to a similar question, funding cannot be used to support the individual in the CBRF since all five conditions must be met.

Pre-admission assessment

1. **Q:** If the person using COP funding was admitted to a CBRF prior to the county's implementation of the pre-admission assessment and is now eligible for waiver, are they not eligible for waiver funding because they did not have a pre-admission assessment?

A: It is not necessary for an individual to receive a pre-admission assessment or consultation prior to the county's implementation of the requirement. For example, if an individual has resided in a facility since December of 1997 and the county implemented their pre-admission assessment in January 1998, they do not need to have had a pre-admission assessment/consultation for use of COP or Waiver funding. Even though the use of Waiver funding is not being used until 2002, the individual's admission to the facility was prior to the implementation of the pre-admission assessment/consultation requirement.

2. **Q:** What if a person is coming from another state, what are the expectations?

A: It is not expected that you or your staff travel to other states to assess someone who is looking at moving to a CBRF. However, it is expected that they receive a pre-admission assessment in order to use COP/Waiver funding. The statute does not provide for much flexibility on this. If the person does not receive one, they will not be eligible for funding in that facility. What you may want to do is contact the CBRFs in your county letting them know your expectations. If the facility has an inquiry from someone who is from another state, let them know that it is critical for potential residents to contact you. Maybe a coordinated visit to the facility and the county can occur when the prospective resident is in the area. Both the pre-admission assessment and pre-admission consultation must be conducted face to face. Families need to be informed that if they want to be eligible for public funding in the future, contacting the county is necessary.

3. **Q:** If a person receives a pre-admission assessment or consultation prior to moving to CBRF A and then moves to CBRF B, do they need to receive another pre-admission assessment/consultation?

- A:** So long as the individual has received a pre-admission assessment at any point prior to admission to a CBRF, it doesn't matter when it was conducted or where the person resided at the time. You may have people that decide not to leave their home, for instance, after receiving a pre-admission assessment. If their needs change two years down the road and they decide to move into a CBRF then, they do not need another pre-admission assessment because they already received one previously. If CBRF A and CBRF B are in different counties, it is "best practice" to offer another assessment to inform the individual of different options in the other county. In fact, in this type of situation it is strongly encouraged since the new county's policies on CBRF use may be different. If the facility is in the same county and the information has changed, it is also considered "best practice" to offer another to update the individual on the changes that may effect them.
4. **Q:** What are CBRFs required to do, what is their obligation?
- A:** State statutes (50.035 (9)) says that "every community-based residential facility shall **inform** all prospective residents of the assessment requirements under...[the pre-admission assessment section in the COP/COP-W/CIP-II statutes]...for the receipt of funds under those sections." Additionally, the Department is currently revising HFS 83 which will include this requirement.
5. **Q:** If a private pay person contacts the county for an assessment, decides to move into a CBRF after the assessment/consultation, and has sufficient funds to pay for his/her care for three years, for example, does another assessment need to be conducted when they run out of money in order to meet this requirement?
- A:** No, not to meet this requirement. The key to this requirement is prior to admission. However, you will need to do an assessment and care plan when the person is eligible for funding.
6. **Q:** If a person didn't receive a pre-admission assessment before admission to a particular CBRF, are they ineligible for funding in all CBRFs, or only that one?
- A:** They are only ineligible for funding in that CBRF for as long as they are a resident there. If they receive a pre-admission assessment prior to moving to another CBRF, they may be eligible to receive funding there. In other words, it does not mean that they are ineligible to receive COP/Waiver funding...they are just ineligible in that setting.
7. **Q:** If a person resided in a CBRF between the time that the county implemented the pre-admission assessment and May 1, 2002, (the date that the other four conditions must be met), do they have to meet the other four conditions to maintain their funding?
- A:** No. Only individuals who seek funding, or become eligible for funding in CBRFs

after May 1st, 2002, must meet the additional four criteria at the time of development of their care plan.

9. **Q:** What if a person is admitted to a facility for respite, and a pre-admission assessment has not been conducted, and the respite placement lasts longer than 28 days? Are they not eligible for funding in the facility if they decide to move there “permanently”?
- A:** Since the pre-admission assessment is intended to inform prospective residents of long-term care options, the Department has determined that if a person was admitted for respite, this assessment is not required because it is not considered a long-term care placement. However, the county can define what they will do in these situations if they so choose. Respite, as defined in HFS 83 is 28 days. If the stay is longer than 28 days, it is not considered respite and a pre-admission assessment would have been required in order to receive funding in the facility if it, in fact, becomes a long-term placement. Counties should communicate with the CBRFs in their counties regarding their own policies for respite placements. Several counties do not exempt respite placements from the pre-admission assessment to avoid any confusion on the part of the facility and county regarding when an assessment needs to be done. Others do not, and find that many CBRFs contact them after admission and tell them that the individual was admitted as respite, but now wants to stay there on a long-term basis. Some facilities have actual admission agreements for respite, others do not. Again, communicate with the facilities in your county and lay out your expectations.

Questions related to CBRF size

1. **Q:** I’m confused....when a facility is larger than 20 beds, when do I need a variance from the Department?
- A:** In almost all cases, a variance will be required. However, variances will only be approved under very limited circumstances. First, there are basically two situations when a variance is not needed: (1) if the facility consists of independent apartments or (2) if the person is a conversion from COP-Regular in the CBRF to the Waivers (the latter will only be pertinent for the first months of 2002). Second, please refer to the memo for information regarding the criteria that must be met in order for a variance to be approved. Variance requests should only be sent to the Department if one of the criteria is met.
2. **Q:** What if I need to place someone in a CBRF with more than 20 beds immediately?
- A:** BALTCR will respond to variance requests within 15 working days. We will do all that we can to respond as quickly as possible to each request. However, the only allowable conditions for COP or COP-W/CIP II funding is described in the numbered memo. In almost all instances, the county will not be able to use these

funding sources in large CBRFs. If a county still chooses to serve the person in an over 20 bed CBRF, it will have to find other funding to do so.

3. **Q:** Can a county have a policy that they won't use COP or Waiver funding in CBRFs with more than 8 beds...or more than 20?

A: Yes. State Statutes (46.27(7)(ck), 46.27(11)(c)5p.& 46.277(5)(d)1p.) and the COP Guidelines (Section 3.01 B. 20.) state that "a county may establish and implement more restrictive conditions on the use of funds...for the provision of services to a person in a CBRF. A county that establishes more restrictive conditions...shall include the conditions in its community options plan."

Waiver Mandate: Conversions from COP-R to COP-W

1. **Q:** If the person has always been on COP-Regular in a CBRF, and due to this change, is now eligible for COP-W, what do care managers need to submit to The Management Group (TMG)?

A: In most instances counties should treat these cases as similar to a new waiver application. Counties will not be reimbursed for a new assessment for these conversions and therefore may use existing assessment information. However, care managers should review and update the assessment and narrative to ensure that the information is current. All other information submitted, including the Health Form, the Functional Screen, and the financial eligibility information, must be current as well. No participant may have a start date prior to September 1, 2001.

2. **Q:** What if the participant was on Waiver, then went to COP because they moved to an ineligible CBRF, and are now waiver eligible again due to this change?

A: If, during calendar year 2001, the participant left the waiver program for a COP funded setting that is now waiver eligible, the care manager does not need to send new application information to TMG. Instead, they should notify TMG that the participant is once again waiver eligible. TMG will send an updated approval letter. The re-certification date will remain the same as it was prior to the move. For example, the participant was newly approved for COP-W in February 2001, then moves to a non-waiver eligible setting the following May. Now, because of the change in statute, that setting has become waiver allowable, effective September 1, 2001. The county notifies TMG that that participant is again waiver eligible. TMG sends an updated approval letter indicating the participant's re-certification is due in February 2002.

3. **Q:** If the participant was on the Waiver program, then moved to an ineligible CBRF and went off the program during which time, if they were still on the waiver, a re-certification would be due, what do counties need to submit to TMG now that the setting is waiver allowable?

A: The county needs to send in all new information (an assessment, narrative/addendum, ISP, health form, Functional Screen and financial information). The participant would also get a new start date. This is necessary because Waiver functional and financial eligibility must be done annually. For example, a participant was on the waiver and re-certified in August, 2000 and then went off the program when they moved to an 18-bed CBRF in May, 2001. Now that setting is waiver allowable. Since the person would have been due for annual waiver re-certification in August, 2001, and it was not done because they were no longer on the program, care managers need to submit a new packet for this individual.

4. **Q:** If the person is residing in a CBRF with more than 20 beds using COP-Regular, does a variance need to be approved before I can convert them to the COP-W?

A: No. Since these individuals have been receiving COP-Regular, it is likely that a variance has been approved for these funds due to grandfathering provisions. These provisions said that if a person resides in a CBRF that was licensed prior to July 1, 1995 or the individual resided in a facility prior to January 1, 1996 they may be eligible for COP funding. The Department has adopted these COP-Regular criteria for COP-W/CIP-II and therefore another variance does not need to be sought. However, if the person residing in a CBRF with more than 20 beds that was licensed before July 29th, 1995 has not been receiving COP funding (is a new applicant), a variance must be sought.

To assist TMG in this process, please include a note that the person you are sending the Waiver packet for was receiving COP in the facility and that this is a conversion. By doing so, TMG will not have to wait for a variance approval.

5. **Q:** Will the department take a disallowance if the county takes longer than the typical allotted time to convert people from COP to the Waiver?

A: No. However, since the reduction in COP-Regular funding was taken as of January, 2002, counties are encouraged to do this as quickly as possible. It is understood that some counties have several people to convert, and others don't have any. Conversions need to be completed within a timeframe that is reasonable given the caseload.